

## BENEFICIARY MONITORING PRIMARY PROVIDER REFERRAL NOTIFICATION / REQUEST

- Read ALL instructions on the reverse side
- See PA 431 and Non-discrimination information on the reverse side

The beneficiary named below requires medical services in addition to those that I provide.  
I am referring this beneficiary to you as discussed with you and the beneficiary.

### SECTION 1 – Beneficiary Information:

Beneficiary Name (Last, First, Middle)			MIhealth ID Number
Street Address			Home Telephone Number
City	State	ZIP Code	Work or Other Telephone Number

### SECTION 2 – Primary Care Provider Information:

Name of Provider			Primary Care Provider ID Number
Business Address			NPI Number
City	State	ZIP Code	Telephone Number

### SECTION 3 – Referred Provider and Appointment Information:

Name of Provider			Date of First Appointment	Time of First Appointment : <input type="checkbox"/> AM <input type="checkbox"/> PM
Business Address / Location of Appointment			Telephone Number	
City	State	ZIP Code	Referred Provider Medicaid ID Number	NPI Number

### SECTION 4 – Reason for Referral and Authorization:

Primary Care Provider Authorizing Signature		Date of Authorization	

**Instructions for form MSA-1302**  
**Beneficiary Monitoring Primary Provider Referral Notification / Request**

**REFERRING PROVIDER INSTRUCTIONS:**

- This form should be used **ONLY** for those beneficiaries that are restricted to a primary provider in the Beneficiary Monitoring Unit.
- Please type or clearly print all applicable information.
- **COPY DISTRIBUTION: (Make photocopies as needed)**
  - ORIGINAL - Mail to MSA, Beneficiary Monitoring Unit
  - PHOTOCOPY - Primary Provider File Copy
  - PHOTOCOPY - Referred Medical Provider File Copy
- The primary provider must mail the original copy of this form to:  
**BENEFICIARY MONITORING UNIT**  
**MEDICAL SERVICES ADMINISTRATION**  
**PO BOX 30479**  
**LANSING MI 48909-7979**

**BENEFICIARY INSTRUCTIONS:**

- You are being referred to another medical provider.
- The name and address of that provider is shown in Section 3 on the front side of this form.
- Your appointment **DATE** and **TIME** are also shown in Section 3.
- You must keep this appointment or call this provider to make another appointment.

**AUTHORITY:** Title XIX of the Social Security Act

**COMPLETION:** Is Voluntary, but is required if Medical Assistance program payment is desired.

The Department of Community Health is an equal opportunity employer services and programs provider.